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Tensions in the epistemic domain and claims of no-knowledge: A study of Swedish medical interaction

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Abstract

This article analyzes the halts in sequential progressivity that are caused by claims of no-knowledge in Swedish medical interaction. The focus is on responsive turns and turn-constructive units that are prefaced by the epistemic disclaimer *jag vet inte* 'I don't know'. We argue that this use of epistemic disclaimers does not primarily display the speaker's lack of knowledge, but that their presence signals interactional problems that are contingent on epistemic asymmetries between the participants. Patient replies that contain an epistemic disclaimer are nonconforming responses and they therefore resist something about the question: the presupposed access to knowledge or the rights to knowledge. The present analysis demonstrates that epistemic tensions, especially in lay–professional interaction, are handled by the lay party using epistemic disclaimers. These can initiate a shift in epistemic posture toward a more independent, more personally accurate formulation of knowledge that somehow contrasts with the professional party's assumptions.

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1. Introduction

Sequential progressivity is one of the key features of smooth social interaction. The components of the turn-taking system “provide for the possibility of transitions with no gap” (Sacks et al., 1974:708). At their completion, turns at talk also serve to evoke a relevant next action by the other party – a principle that is most obvious in the organization of adjacency pairs (Sacks, 1987). For example, a request for information makes an answer that provides a piece of appropriate information relevant as the next action (Stivers, 2011:104). Halts in progressivity nonetheless occur, such as when the recipient of a request has trouble hearing or understanding the first action and produces a *What?* instead of the relevant answer. These types of responses then initiate repair sequences, which mark a break in the ongoing course of action, but which eventually work to mend the break in intersubjectivity and restore progressivity (Heritage, 2007; Sacks et al., 1977).

When a speaker uses responses to claim a lack of knowledge, this is arguably an interactional move that may effectively hinder the progressivity. No-knowledge responses to questions share one quality of non-answers in that they are contributions that fail to deliver the information that the questioner is seeking (Stivers and Robinson, 2006). As Hutchby (2002) demonstrates, the non-cooperative feature of no-knowledge responses may be used strategically to avoid talking about specific topics (see also Tsui, 1991; Weatherall, 2011). The objective of this study is to investigate

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patients' claims of no-knowledge in their responses to questions in medical interviews where patients are seeking relief for their rheumatism and fibromyalgia. While it is in the patients' best interest to co-operate with the attending physician, the data display frequent claims of no-knowledge on the part of the patients. In fact, a response containing a claim of no-knowledge usually reflects *some* knowledge rather than a lack thereof (compare Beach and Metzger, 1997; Tsui, 1991). Specifically, we explore question/answer-sequences where speakers, when answering, claim no-knowledge but who nonetheless subsequently provide a candidate answer to the question. We argue that what is apparently logical paradox is in fact a resource for speakers to signal interactional problems that are contingent on epistemic asymmetries between the participants. In short, claiming no-knowledge becomes a resource for dealing with the tension between the biomedical, professional knowledge and the personal, lay experience of health issues.

This is indicated by the fact that no-knowledge claims are by their very nature nonconforming to type-specifying questions. These include questions that request a certain type of reply: interrogatives request a yes/no-answer, WH-questions request places, times, reasons, circumstances, or individuals, etc. (compare Heritage, 2012; Heritage and Raymond, 2005; Raymond, 2003). Extract (1) serves as an illustration: the doctor is inquiring about the patient's general well-being, aside from the strictly physical experience of the illness, and has moved on to the patient's psychological state. The extract begins with the doctor asking whether the patient is prone to depression, in other words, this is a question that is based on the doctor's professional knowledge; he has made the assumption that depression might be a side-effect of the illness.

(1) INK:8. D=doctor, P=patient.

01 D: depressiv,
'depressive,'

02 (0.8)

03 P: #n:ä# ja vet int-
no I know not
'no I don't know-'

04 (0.3)

05 P: .hh

06 (0.4)

07 P: eh hh

08 (0.6)

09 P: m: man blir ju- .hh
PRT GNR becomes PRT
'hm you do get'

10 .hh int vet ja ↓depressiv men ↓ #e[:#]
not know I depressive but
'I don't know depressive but erm'

11 D: [.h]

- 12 P: no blir man ju lite så hä
 PRT becomes GNR PRT a.little DEM
 'sure you do get a little like'
- 13 irriterad om man int sover ord[↑]entlit å?
 irritated if GNR not speeps properly and
 'annoyed if you don't sleep properly and'
- 14 #å# om man har ont #hela tiden
 and if GNR has pain whole time-DEF
 'and if there is constant pain'
- 15 s[å,#]
 'so'
- 16 D: [m] mm:m
- 17 P: #e# no blir man [ju lite] så här
 PRT PRT becomes GNR PRT a.little DEM
 'um sure you do become a little sort of'
- 18 D: [mm.]
- 19 (1.1)
- 20 D: °preci[s.°]
 'right'
- 21 P: [att in]t e man ju p[å-]
 that not is GNR PRT on
 'so you're not'
- 22 D: [°n]ä°
 'no'
- 23 P: på *gott humör* pre[cis int.
 on good mood precisely not
 'exactly in a good mood'
- 24 D: [mm.]

Although the doctor's question in line 1 is highly elliptic, it is type-specifying, and requests the specific response type of a yes/no-answer. The patient's reply in line 3 suggests that supplying this type of answer to the question is somehow problematic: *nå ja vet inte* 'no I don't know.' While the no-preface grammatically conforms to the yes/no-interrogative, the 'I don't know'

suggests something less definitive than the type-conforming ‘no,’ as it circumvents the sequential consequences of what a yes or a no would lead to (compare Raymond, 2003:949). This disclaiming of knowledge is interrupted in line 3 and is not considered to be a sufficient response by the doctor who does not take the turn at this point. After hesitating slightly, the patient resumes in line 9, pauses again, and inserts a knowledge disclaimer before producing the word *depressive* ‘depressive’ in line 10. The formulation brings this word into question, which is introduced in the doctor’s initiative. The patient then continues talking and explains how one’s physical condition and sleep deprivation affect one’s mood, concluding that *int e man ju på gott humör int* ‘it’s not like one’s in a good mood, right’ in lines 21 and 23. The doctor–patient negotiation on the correct label for the patient’s experience manifests itself as a clash between the participants’ differing access to relevant knowledge. This refers to the doctor’s professional experience, which makes a question about depression relevant, and the patient’s personal access to her experiences and feelings. The markers of no-knowledge therefore highlight the presuppositions of the question. In other words, the patient is not willing to accept the full consequence of agreeing with the description ‘depressive,’ which is not only a psychological state, but also a choice of terminology that turns the psychological state into something pathological, treatable, and, in some societies, something rather shameful. As it transpires, due to the side effects of her illness the patient is not feeling entirely well, but she is unwilling to concede to the doctor’s proposed diagnosis.

Previous research on epistemic disclaimers has focused on their role in moves that are dispreferred, uncertain, and resisting (see Lindström et al., 2016). These uses are characterized as pragmatic or interactive, to distinguish them from the literal (or cognitive) meaning of ‘I don’t know’ as a straightforward stand-alone response to an information-seeking question. In our present study, our main objective is to expand on previous linguistic knowledge of epistemic disclaimers by exploring their use in medical interviews, concentrating on how the specific circumstances of medical interaction provide fertile grounds for the use of these expressions. Hence, this study also adds to the vast amount of conversation analytic research on medical interviews (compare Maynard and Heritage, 2005). We will particularly relate to the participants’ epistemic asymmetries and how the patients cope with these asymmetries by claiming no-knowledge. To address this, we focus on the sequences that involve patients marking their personal, subjective position in their interaction with medical professionals who, nonetheless, possess superior biomedical knowledge of the matters discussed during consultations. The analysis therefore contributes to the discussion of epistemic dimensions in conversations, particularly those concerning access and primacy (see Stivers et al., 2011). This analysis also adds to the research conducted on epistemic disclaimers (compare among many others Degand et al., 2013; Tsui, 1991; Weatherall, 2011; Östman, 1981) in that the data include two varieties of Swedish: Sweden-Swedish and Finland-Swedish (see Norby et al., 2012). Parallel to the other studies in this collection, the present analysis will thus contribute to generalizability across languages.

The following section will present a brief orientation of basic epistemic asymmetries in medical interaction with particular emphasis on the dimensions of epistemic access, primacy, and responsibility. Section 3 introduces the data and the principles for the collection of actual cases for analysis, that is, turn-prefacing epistemic disclaimers. Section 4 presents our core analysis of epistemic disclaimers as a resource for dealing with the participants’ different positions in relation to epistemic access and epistemic rights. The article closes with conclusions drawn from the analysis (Section 5).

2. Background: epistemic asymmetries in medical interaction

On a general level, the doctor and the patient share the same goal during a medical consultation in that the patient should receive help and be cured. Medical interaction is nonetheless characterized by several asymmetries that are caused by the differences in the participant roles, knowledge bases, and expectations (see Drew, 1991). While the doctor is the expert who possesses formal biomedical knowledge and authority over health and medicine, the patient has a social and personal lay perspective on such issues. This means that doctors orient to the general, objective knowledge and professional practices in their field, which may clash with patients’ particular and subjective experience of their symptoms and ailments. As an expert, the doctor is responsible for an agenda that is relevant to the patient’s needs, whereas the patient is entitled to receive relevant information and treatment.

With regard to claims of no-knowledge, the key interactional issue that arises is the asymmetries in the orientations to the epistemic domain. To make an objective conclusion and diagnosis, the doctor requires specific and often measurable information, such as the duration, location, and intensity of the patient’s pain. However, the patient may have difficulty in providing this type of information because the subjective experience of pain is acute and prevalent. As a consequence, it may be demanding to describe pain in exact terms if the patient has not made notes of the times and the physical symptoms involved. We argue that this type of problem was illustrated by extract (1): the doctor was seeking a specific label for the patient’s mental state, whereas the patient expressed trouble in finding one word that would capture and specify her situation.

With reference to Stivers et al. (2011), we find it analytically beneficial to relate epistemic asymmetries in medical consultations to the dimensions of access, primacy, and responsibility, as illustrated in Table 1.

As regards epistemic access, the patients have direct, first-hand knowledge of their own physical experience, whereas the doctors have superior general knowledge of medical symptoms and their causes. When we consider epistemic primacy, the patients are entitled to their subjective experience as well as their right to communicate it. The doctors instead

Table 1
Epistemic dimensions and asymmetries in medical interaction.

Dimension/participant	Epistemic access	Epistemic primacy	Epistemic responsibility
Patient	First-hand knowledge of one's physical/mental experience	Right to describe one's physical/mental experience	Provides adequate information on one's physical/mental experience
Doctor	Professional knowledge based on medical education and experience	Authority to decide what is relevant and to diagnose and prescribe	Provides adequate medical information and treatment

have the authority to decide what is relevant to discuss, diagnose, and suggest as the patient's treatment. The doctors are responsible for giving adequate diagnoses, information, and treatments, but this task depends on intersubjective trust. This means that the information that the patients provide likewise needs to be adequate and truthful. Indeed, the doctors may be held accountable for withholding requested information, which we illustrate in extract (2): the doctor claims a lack of knowledge with his stand-alone disclaimer as an answer to the patient's question in line 4:

(2) INK:12.

- 01 P: >va gör he de lymfaterapin (.)
what does DEM lymphatic-therapy-DEF
'what does it do, the lymphatic therapy (.)'
- 02 va händer i kroppen<
what happens in body-DEF
'what does it do to the body'
- 03 (.)
- 04 D: ja vet int.
I know not
'I don't know'
- 05 (.)
- 06 P: du vet int he.
you know not that
'you don't know that'
- 07 D: fråga henne.
'ask her'
- 08 (.)
- 09 D: *(nä) de vet ja int faktist.*
no that know I not really
'(no) I actually don't know that'

The patient is interested in testing lymphatic therapy and the doctor has encouraged her to pursue that. In line 1, the patient inquires as to how the therapy works and the doctor replies to this, *ja vet int* 'I don't know.' This is followed by the patient's somewhat surprised receipt, *du vet int he* 'you don't know that.' The doctor then refers to the physiotherapist

(*fråga henne* ‘ask her’) as a source of knowledge. In line 9, he continues on to restate, this time with a smiley voice, that he really does not know how the therapy works – the adverb *faktiskt*, ‘actually, factually’ implies that the content of what is being said runs counter to the other party’s expectations. These claims of no-knowledge by doctors are rare in our data, and the instantiation in (2) might be explained by the fact that lymphatic therapy is not a part of Western standard medicine. Hence, the doctor problematizes his responsibility to provide information on something that is assumed to be within his area of knowledge (see [Keevallik, 2011:193](#)). However, rather than signal an unwillingness to answer, he claims no-knowledge. Not being able to contribute leaves the doctor less culpable than if he had appeared unwilling to supply information about the treatment (compare [Clayman, 2002](#); [Heritage, 1988](#)).

Doctors may be equally surprised when patients claim a lack of knowledge in matters that they alone are expected to have primary epistemic access to. Extract (3) illustrates this type of orientation: the doctor has asked whether the symptoms that the patient has described are something that her parents have suffered from, and the patient has responded by talking about her elderly mother. We enter the transcript when the doctor poses a specifying question (appended to an earlier patient turn which is not seen here): *när hon va i samma ålder* ‘when she [the patient’s mother] was at the same age [as the patient herself at the time of speaking]?’:

(3) INK:12.

- 01 D: när hon va i samma ålder
when she was in same age
‘when she was the same age’
- 02 (.)
- 03 P: ja veit int.
I know not
‘I don’t know’
- 04 D: aj [du vet int.
PRT you know not
‘oh [you don’t know’
- 05 P: [mamm ha vari arbetsam å gai (ja)
mom has been hard.working and gone PRT
‘mom’s been hard working and walking (well)’
- 06 [nu allti å () gör,
PRT always and does
‘all the time and () does,’
- 07 D: [hon ha inte prata om de.
she has not talked on it
‘she hasn’t talked about it.’
- 08 (.)
- 09 P: nä:ä
‘no’

In line 3, the patient claims to lack knowledge by using the regional form *ja veit int*, which is an utterance that has the prosodic features of a completed reply, and the doctor responds to this as something unexpected. His turn in line 4 is initiated by his change of state token *aj* 'oh,' which is typical of Finland Swedish (see Lindström and Wide, 2015) and interprets the 'I don't know' response as full-fledged in the sequential context (although the patient continues in line 5). Family history, including diseases and ailments, is potentially something that the patient can have access to but otherwise, her mother's experiences would have only been known to her if the mother had discussed them with her. This type of knowledge is therefore occasioned (Keevallik, 2011:196; Pomerantz, 1980:187). The doctor draws the appropriate conclusion and acknowledges the evidential background for the patient's lack of knowledge in line 7.

These types of epistemic landscapes tend to create tensions between the doctors' and patients' orientations to knowledge. In the following, we focus specifically on the turn or TCU-prefacing *jag vet inte* 'I don't know' (with some formal variants), with the aim of specifying what these epistemic tensions entail and how they are dealt with in the interactional work displayed by the participants.

3. Data and collection

The data consist of two corpora of medical interactions, one where the interactants speak Sweden-Swedish varieties and the other where they speak Finland-Swedish varieties. The Sweden-Swedish data (LOP) were collected at a rheumatology clinic and consist of 15 consultations for a total length of 7 h. The interactions include both initial visits, when the patient enrolls at the clinic, as well as visits by more experienced patients who have been treated for some time (Melander Marttala, 1995). The Finland-Swedish data (INK) are from a similar environment and also include both initial visits and follow-up visits, amounting to 20 consultations with a total length of 13 h (Lindholm, 2003). The patients in the data from Finland suffer from fibromyalgia.¹ Both sets of data concentrate on the patients' experiences of pain and the related treatment, and the interaction between the doctors and patients focuses on the patient's experience and recollection as well as the doctor's history-taking. A physical examination also occurs during the consultations. The data were video recorded and collected with the informed consent of all participants and was subsequently transcribed. The extracts have an idiomatic English translation. A word-by-word gloss is provided when the word order in the translation differs from the original.

From this data, we have discovered 29 excerpts of variations in the Swedish epistemic disclaimer *jag vet inte* 'I don't know,' that occur within patient turns (compare Dutch *ik weet niet*, German *ich weiss nicht*; compare also Helmer et al., 2016). Most of these instances have the straight word order *jag vet inte*, but some examples contain an inverted word order with the negation first (*int vet jag*), or with an anaphoric pronoun (*det* 'that') in the initial position (*det vet jag inte*). These variations occur due to the structural properties of Swedish and all of them have a routinized status. The common principle for the excerpts was to include uses with the epistemic disclaimer constituting some form of prefatory move in patient response turns, either as a separate turn constructional unit, or as a preface to a turn constructional unit (TCU); (compare Schegloff, 1996; Weatherall, 2011). We are therefore interested in the pragmatic premodifying properties of the knowledge disclaimer within the realm of a conversational turn. The occurrences in stand-alone answers were excluded, because these differ from the uses of the epistemic disclaimer as a turn-framing device; for a discussion of the differences, see Keevallik (2011) on Estonian. The meaning of *jag vet inte* in stand-alone answers may be literal or remain implicit until a further course of interaction unfolds. We have also not included instances of *jag vet inte* that were followed by a complement clause, such as *jag vet inte om det är sant* 'I don't know whether it is true,' *jag vet inte hur det är möjligt* 'I don't know how it is possible.' In these cases, *jag vet inte* is not a preface because the meaning is literal and its target specific, which is expressed in the subsequent dependent clause.

The three forms of the epistemic disclaimer – *jag vet inte*, *int vet jag*, and *det vet jag inte* – have different distributions in the data. The first variant, with the subject first, is clearly the most frequent and general form, whereas the second variant (with negation first) only occurs in the consultations recorded in Finland (compare Laury and Helasvuo, 2016, on negation-first disclaimers in Finnish). However, this variant is not as frequent as has been reported in everyday Finland-Swedish conversation. A study of Helsinki Swedish teenage talk reported the proportion between *jag vet inte* and *int vet jag* to be approximately 50/50 (J. Lindström, 2009), whereas the ratio in the INK corpus is 29/5 (note that stand-alone disclaimers were included in these general counts, but not in our collection of excerpts). One reason for the low

¹ Fibromyalgia is a chronic disease that is characterized by widespread pain, fatigue, and joint stiffness. As the data from Sweden were collected at a rheumatology clinic, we could say that the ailments the patients suffer from appear to be sufficiently similar in both data sets.

frequency of the negation-first disclaimers can be their general pragmatic signal value: they commonly appear in turns that by nature are overtly resisting or rejecting (J. Lindström, 2014), as we can also see in extract (1), line 10. This might be the reason that patients avoid sending such interactional signals during medical interviews, which are basically cooperative in nature.

Finally, the variant *det vet jag inte* as a prefatory move occurs in the data only three times, and owing to this low frequency, it is not possible to claim anything decisive about its pragmatic meaning. Nonetheless, these instances occur in the Sweden-Swedish dataset and they occur when a patient is confronted with a question that exceeds the limits of his or her competence, that is, there is an issue with epistemic access. An example of this use is shown in extract (4); at this point of the transcript, the patient admits to having ingested non-prescription painkillers before the consultation.

(4) LOP:3.

- 01 P: nu fuska ja fak[tist] å
now cheated I really and
'I actually cheated now and'
- 02 D: [jaa]
'yeah'
- 03 P: tog #e- en en Magnecyl inn[an] ja gick
took a a Magnecyl before I went
'took an- an an Aspirin before I left'
- 04 D: [°.ah°]
- 05 P: för att ja [skulle kunna ta-#
because I would be.able take
'to be able to take-'
- 06 D: [hjälper hjälper en Magnecyl,
helps helps a Magnecyl
'does does an Aspirin help,'
- 07 P: de #vet# ja #in#te. (.)
that know I not
'I don't know that'
- 08 °men ja kan ju inbilla mej att de [gör] de.°
but I can PRT imagine RFL that it does it
'but I can tell myself that it does.'
- 09 [mm]

As the patient takes painkillers before a medical consultation, this could affect the outcome of the consultation, and this is something that is suggested by the patient's choice of words in line 1, *nu fuska ja faktist* 'actually I cheated this time.'

However, the doctor does not reproach her in line 6, but instead asks if the substance has had any effect; formulated in this way, the question puts the patient's own experience of the physical effects at stake. In line 7, the patient subsequently claims no-knowledge, *de vet ja inte* 'that I don't know,' and continues on to suggest that the supposed effect might be imaginary. A 'yes' or 'no' response here, which would match the form of the question, would be inadequate, and would be over-reaching as to what she can actually know, or claim to know, about the effects of the drug. The topicalization of the object (*det* 'that') in this variant of epistemic disclaimer may indicate that the disclaimer is more specific than the variants that lack the anaphoric pronoun; in other words, the speaker is expressly distancing herself from an element in the previous turn (compare [Karlsson, 2006:143–144](#)).

4. Analysis: dealing with epistemic access and primacy

In the following subsections, we analyze the patients' use of turn-prefacing or TCU-prefacing epistemic disclaimers. In the former case, the epistemic disclaimer constitutes a TCU of its own, but in both cases, it is a prefatory interactional move that is followed by more talk by the same speaker (compare [Weatherall, 2011](#)). The analysis accounts for epistemic asymmetries that locally occur in question–answer sequences during doctor–patient interactions. By focusing on the dynamics between the doctors' questions, the patients' answers, and the participants' epistemic statuses (see Section 2 above), we identify two types of contexts that produce turn/TCU-framing 'I don't know's'. The first is when participants are dealing with differing epistemic access and the second is when participants' epistemic rights (primacy) are (re)negotiated.

4.1. Differences in epistemic access: heading off an inadequate assumption

Extract (4) is an example of problems with epistemic access, and possibly also with epistemic primacy in the medical domain, which were oriented to by using the negative epistemic marker. In the following, we discuss instances of the tension between the speakers' access domain surfacing even more clearly. The doctors' questions during patient history-taking inevitably contain propositions that presuppose circumstances about the illness and the patient's experiences of the illness. In effect, by posing a question in a certain manner, the doctor may preframe a certain type of answer. When the doctors use their professional judgements to diagnose patients, the assumptions underlying their questions often stem from what they deem relevant to describe. As was seen in extract (1), these types of questions may suggest descriptive labels that the patient cannot accept because they contradict with what the patient knows about her own condition. Extract (5) is a further example; the physician is enquiring about the character and location of the pain the patient is experiencing:

(5) LOP:12.

01 D: har du nå ont i (.) nacken eller=
have you some pain in neck-DEF or
'do you have any pain in (.) your neck or'

02 P: .nähh: ingenting sånt.
no nothing such
'no nothing like that'

03 D: ont i ryggen eller [°höften¿°]
pain in back-DEF or hip-DEF
'pain in your back or hip'

04 P: [nä: ja ↑rygg↓en.] (.)
no yes back-DEF
'no yes my back (.)'

- 05 a se **ja vet inte** ja har inte ont
 PRT PRT I know not I have not pain
 'yeah, see, **I don't know** I'm not in pain'
- 06 men de känns:=ja blir trött=
 but it feels I become tired
 'but it feels: I get tired'
- 07 =men de kan ju va kondition som=
 but it can PRT be condition that
 'but that could be my bad shape that-'
- 08 =ja e otränad igen nu.
 I am untrained again now
 'I'm unfit again now.'
- 09 D: mm:mč
- 10 P: så de känns:? (.)
 'so it feels'
- 11 de e inte värk men #eh#- (.)
 it is not pain but
 'it's not pain but um-'
- 12 de e (.) länd#ryggen liksom#,
 it is lower.back-DEF like
 'it's like (.) my lower back right,'
- 13 D: mm:m

In line 1, the doctor asks the patient if she is experiencing pain in her neck, which she denies. The doctor then continues by adding two further candidates for the location of her pain: either her back or hip. The patient's initial response is negative, but she immediately reacts to the physical location *ryggen* 'the back' in line 4. However, in line 5, the patient problematizes the question: *ja vet inte ja har inte ont* 'I don't know I'm not in pain,' followed by three lines, 6–8, that constitute attempts to narrow down the sensation that corresponds to something closer to her own experience than 'pain.' The doctor only gives a minimal response, and the patient continues to specify the problem. The question presupposes that pain is a relevant focus, something that patients would indeed normally see treatment for at a rheumatology clinic. For the patient, however, 'pain' is not the correct word to describe her problems, even though she has had some problems with her lower back. The double proposition of the question, that there is pain and that it could be located in the patient's back, makes it difficult to reply to when both propositions are not relevant to the patient (compare Linell et al., 2003).

Extract (6) contains a similar defiance of an assumption that has been embedded in the question. In line 1, the doctor requests information by using a declarative statement concerning circumstances that are clearly within the patient's epistemic domain (compare Labov and Fanshel, 1977). The format of the question suggests that the doctor is relatively certain of his proposition; the statement is something of a conclusion based on a patient's previous statement regarding how good it is to have people to talk to about her ailment.

(6) INK:8.

01 D: ni har en ganska aktiv förening där=
you.PL have a rather active club there
'you've got a rather active club there'

02 P: =ne ja vet int vi- .h alltså Irina å ja
no I know not we PRT Irina and I
'nah I don't know we- .h that is Irina and I'

03 ha egentligen jo- (0.3) jobba tillsammans [förut] att
have actually worked together before that
'have actually wo- worked together before so'

04 D: [mt]

05 D: precis j[å]
'right yes'

06 P: [att] vi ha int egentligen vari så där aktiva
that we have not actually been DEM active-PL
'so we haven't actually been all that active'

07 den e ju ganska n[y den hä [föreningen
it is PRT fairly new DEM club-DEF
'it's fairly new this club, you know'

08 D: [jå [jå
'yes yes'

09 P: [i ((Lillköping)) att vi ha int
in Lillköping that we have not
'in Lillköping so we haven't'

10 D: [jå [.ju
'yes right'

11 (0.2)

12 D: jåjå
yes-yes
'yeah yeah'

13 (0.3)

14 P: ha int egentligen vari så hemst ak[tiva i den]
 have not actually been so awful active-PL in it
 'haven't actually been all that active there'

The patient's response in line 2, *ne ja vet int* 'nah I don't know,' suggests that although the doctor bases his statement on information provided by a person with epistemic access and whose epistemic domain the issue belongs to (Keevallik, 2011), there is something about his proposition that the patient cannot accept without modification. The proposition suggested in the question is, on the one hand, that the club is active, and on the other, that the club (and its level of activity) is relevant to the patient's reported feeling of relief about having people in the same situation to talk to. The patient proceeds to explain how the doctor's conclusion focuses on the wrong point – the support she was referring to hinges not so much on the club as it does on one of the members being a previous co-worker. This is further elaborated in lines 6–9 and 14, where the doctor's question is explicitly challenged; the club was formed recently and has not yet organized many activities. By resisting the format of the question and the doctor's claim to be able to accurately reformulate the patient's information, she has an opportunity to set the record straight. In other words, she reclaims her epistemic primacy, asserting herself as the primary interpreter of the matters within her epistemic domain.

Both extracts (5) and (6) are examples of the patient utilizing a statement of no-knowledge to correct an assumption or an interpretation of something that is not within the questioner's primary epistemic reach. In (5), the doctors' questions suggest physical and psychological experiences that might be relevant for the patient to accept or reject in a yes/no-polarity format. A question formed as a declarative (6) likewise creates an opportunity to respond in a yes/no-polarity format. In both extracts, the patients reject the type-specifying format and instead accept only part of the underlying propositions of the question, presenting a somewhat more nuanced description of what they accept as relevant. An epistemic disclaimer serves as a bridge for nuanced formulation, which signals that one is distancing oneself from what has been said previously.

4.2. Negotiating epistemic rights by taking a more independent stand

The above extracts have illustrated sequences that contain epistemic asymmetries leading to interactive failure; the doctors posed questions based on presuppositions that conflicted with the patient's primary knowledge. Closely intertwined with these types of interactionally problematic situations is the question of the participants' epistemic primacy – who has the right to (adequately) know and what. This was also evident in extract (6). In the following, we will discuss further instances in which epistemic rights are at stake and in which the patient adopts a more independent stand in relation to the doctor's a priori epistemic authority. Extract (7) serves as a mild and embedded example of these types of interactional tensions, which resembles extract (5), as here the doctor asks the patient whether she can localize her pain, suggesting her arms, legs, and back as possible locations. In other words, he makes assumptions based on his medical experience. The patient initiates a response by orienting to the doctor's suggestions and confirming them. In line 6, however, she produces *ja vet int* 'I don't know,' which marks a shift in her epistemic posture.

(7) INK:10.

01 D: nå dedär: ä (.) kan du säga att du ha värkt (.)
 PRT PRT PRT can you say that you have ached
 'right um (.) would you say that there is pain (.)'

02 i (.) överarmar å i ben å (.) i underarmar (.)
 in upperarms and in legs and in forearms
 'in (.) your upper arms and your legs and (.) forearms'

- 03 [i ryggen,
in back-DEF
'in your back'
- 04 P: [i ry- i ryggen a ha [också (.) [mm (.) å i benen också [i i
in in back-DEF PRT also PRT and in legs-DEF also in in
'in my back uhhuh also (.) mm (.) and in my legs too in in'
- 05 D: [i ryggen [jå [mm
in back-DEF yes PRT
'in your back, right, mm'
- 06 P: **ja vet int** (.) ibland s- (.) tycke ja bara att ja inbilla me
I know not occasionally think I just that I imagine RFL
'**I don't know** (.) sometimes (.) I just think that I'm imagining'
- 07 att [va ha ja fö fel att (.) att
that what have I for fault that that
'like what's wrong with me (.) so that'
- 08 D: [mm
- 09 P: de kan ju int va sån- i- int kan ja ju va sjuk genom
it can PRT not be such not can I PRT be sick through
'it can't be like this- I can't be sick all through'
- 10 hela [kroppen int.
whole body-DEF not
'my body, right.'
- 11 D: [mm
- 12 (.)
- 13 D: nå de e å möjlit förs*tås*.
PRT it is also possible of.course
'well that's possible too of course.'

The contribution that follows the claim of no-knowledge is framed as an incidental subjective experience, referring to the 'occasionally I just think that I'm imagining' in line 6. This latter part of the patient's turn is thus devoted to communicating a personal, more independent perspective, which is clinically less exact but it is apparently subjectively more accurate because she might feel pain throughout her whole body. The hedged and negatively framed formulations in the latter part of the patient's turn (*int kan ja ju va sjuk genom hela kroppen int* 'I can't be sick all through my body, right,' lines 9–10 and 13) indicate that claiming epistemic primacy is a socially delicate issue in a context that involves the doctor's domain in the institutional order (Gill et al., 2001). The epistemic disclaimer marks this dispreferred shift in posture from an initial

concessive stance to her making a suggestion, or even devising her own hypothesis. At the end of the extract in line 13, the doctor acknowledges the patient's sentiments and the relevance of her description with a smiley voice.

Epistemic primacy becomes an even clearer issue in extract (8). The patient has reported that she is taking rather large doses of a certain (mild) medication ('ten capsules a day') and that this is expensive. In line 1, the doctor states that the amount seems large and poses a challenging question (*behöver du så mycke* 'do you need that much?'). The patient replies in line 4 in a turn prefaced with the particle *nå* (A. Lindström, 2016), which may signal a dispreferred, or at least a non-straightforward, answer, followed by *ja vet int*. As in (7), the turn continues with a mitigating incidental description (*ibland sen så* 'occasionally then'), but this line of reasoning is aborted; instead, the patient continues by declaring that some days she does not take the medication at all, which can be interpreted as a defensive move in lines 5–6.

(8) INK:13.

01 D: de låter ganska mycke [de ja
that sounds quite much that yes
'that sounds like quite a lot, yes'

02 P: [ja
'yes'

03 D: ö: behöver du så mycke (.) [()
PRT need you so much
'um do you need that much (.)'

04 P: [nå ja vet int ibland sen så,
PRT I know not occasionally then PRT
'well I don't know sometimes then,'

05 nå nu ha ja int kanske tagi igen (.) på nån,
PRT now have I not maybe taken again on some
'well, now I haven't had any again (.) for,'

06 några dagar ha ja vari utan [helt.
some-PL days have I been without wholly
'for a few days I haven't taken any at all.'

07 D: [mm:m

08 (0.4)

09 P: men nu tar ja då när ja känner att att ja behöver=
but PRT take I then when I feel that that I need
'but I do take some when I feel the need'

10 =[egentligen tycker ja att ja känner de på mej.
actually think I that I feel it on me
'actually I think I can feel it.'

- 11 D: [mm:m
- 12 D: oke[j
 'okay'
- 13 P: [att ja kan ha pauser #nog#.
 that I can have pauses PRT
 'so I can have breaks definitely'
- 14 D: jä:å
 yeah
 'right'
- 15 P: .jä
 'yeah'
- 16 D: jä:å
 yeah
 'right'
- 17 P: °för att int e de ju bra heller°
 because not is it PRT good either
 '°because it's certainly not good either°'
- 18 (0.3)
- 19 för levern så här att man tar massor me [.h
 for liver-DEF like this that GNR takes masses with
 'for the liver that you take a bunch of'
- 20 D: [mm
- 21 P: olika saker.
 different things
 'diverse stuff'
- 22 D: ja å om int annat så blir de som sagt dyrt.
 yes and if not else PRT becomes it as said dear
 'yes, and if nothing else, as (you) said, it gets expensive.'

In line 9, following a short pause, the patient adopts a more definite stand: she states that she takes the medication when she feels that she needs it, underlining in line 10 that she is able to identify and regulate her own needs. By claiming this, the patient assumes a noticeable independent epistemic posture, claiming epistemic primacy in the medical issue being discussed. The turn-initial epistemic disclaimer in line 4 can therefore be analyzed as a prefatory

marker. It prefaces the distance-taking from the physician's challenging question and the epistemic primacy incorporated in it, foreshadowing the patient's shift to an independent stance in lines 9–10. The doctor responds with a series of continuers, leaving the turn for the patient, who in lines 17–21 concedes that large doses can damage the liver. This concession may be an orientation to pre-empt a possible critical professional stance from the physician, but it also displays that the patient is appropriately oriented to lay versus professional knowledge in relation to health issues (compare Gill et al., 2001). The physician does not reclaim epistemic primacy in that sequence, but only reiterates (line 22) what the patient initially brought up (note the phrase *som sagt* 'as was/you said'): that taking large quantities of medicine is (at the very least) an economic issue.

Extracts (7) and (8) both illustrate tensions that arise due to the participants' orientations to epistemic primacy and their shifts in epistemic posture as a result of the tensions. The institutional frame provides the doctor with epistemic primacy and, consequently, when the patient takes the initiative in the medical domain, it is a delicate matter. These types of initiatives are therefore surrounded by signals of their socially dispreferred nature: the patient may produce partly conforming or conceding answers and frame her independent stand with hedging devices. Together with other hedging devices, the epistemic disclaimer signals that the patient is reluctant to accept the line of reasoning suggested by the other; instead, the patient is heading to a more independent epistemic position (compare Heritage, 2002). In doing this, the patient asserts more agency over her response (Stivers and Hayashi, 2010; Stivers et al., 2011:22), which may enable her, for example, to claim health-monitoring competence, as is clearly the case in (8) (see Gill et al., 2001).

5. Conclusions

The present analysis points to interactional practices used to assert one's relative epistemic positioning (Heritage, 2012; Heritage and Raymond, 2012). The assumptions of the questioner concerning the knowledgeability of the conversational partner can be adjusted in the response turn by expressing that one has no knowledge of the matter being discussed. We therefore argue that explicitly claiming no-knowledge is not the same as providing a non-answer response (compare Stivers and Hayashi, 2010:23). Instead, such responses resist something about the question (compare Keevallik, 2011). By studying response turns that are framed by the epistemic disclaimer *jag vet inte*, we have discerned certain interactional organizing patterns. These types of responses are superficially anomalous: the speaker first denies knowledge but then, and in the continuation of the response, still maintains having some type of knowledge. Most of the previous studies on turn-prefacing epistemic disclaimers demonstrate that they signal the speaker's uncertainty regarding what is being said and that the epistemic disclaimer therefore serves as a hedge (see Lindström et al., in 2016). In the present study, we have extended this further in determining what could constitute these markings of uncertainty in the context of medical interaction.

One common feature of responses prefaced with an epistemic disclaimer is that the speaker (patient) can flag an answer as less straightforward so that the assumptions embedded in the question may be faulty, conflicting with what the patient has access to, or the question may infringe on the recipient's (experienced) epistemic rights. The epistemic disclaimer thus marks an interactional problem at hand and the speaker's hesitancy regarding how to proceed with a socially delicate or complicated upcoming contribution. By claiming superior epistemic access, the patient may appear to be more knowledgeable than the doctor, and by claiming epistemic rights, the patient may take initiatives that are conventionally reserved for the medical professional (for example, suggesting diagnosis or medication). Thus, the source of tensions in these epistemic dimensions is the lay–professional relation, and it is through epistemic disclaimers that the speakers can mark their awareness of such tensions and navigate among them.

The prefacing epistemic disclaimer as a unit can be analyzed as a pragmatic marker that simultaneously links backwards and points forwards in discourse. The preceding move is marked as being problematic by 'I don't know', but it also signals that the talk within its scope is somehow complicated. In other words, the disclaimer projects a modification of the proposition put forward by the questioner. In the examples analyzed in this study, the patient is constructed as having epistemic access to certain domains. Answering with a no-knowledge claim involves re-positioning the speaker from knowledgeable to non-knowledgeable, or rather, to knowledgeable of something other than what the question requested. This is how the speaker claims more agency over her response and works toward resolving the epistemic tension that has surfaced in the interactional micro-situation.

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Appendix

Transcription symbols

.	falling intonation
,	level intonation
ˊ	slightly rising intonation
?	rising intonation
-	cut off
[start of overlapping talk
]	point where overlapping talk stops
(.)	micropause, less than 0.2 s
(0.5)	silences timed in tenths of a second
=	"latching", i.e. no silence between two adjacent utterances
> <	talk inside is at a faster pace than the surrounding talk
:	lengthening of a sound
mm:m	stretched pronunciation (legato)
en-	cut off
<u>en</u>	emphasis indicated by underlining
en	smile voice
#en#	creaky voice
°en°	talk inside is more quiet than the surrounding talk
(en)	uncertain transcription
()	inaudible words
.en	word pronounced with initial inhalation
.hh	audible inhalation (the more h's, the more aspiration)
hh	audible exhalation (length as above)

Glossing abbreviations

DEF	definite
DEM	demonstrative
GNR	generic 3rd person pronoun (cf. 'one')
PL	plural
PRT	(discourse) particle
RFL	reflexive (pronoun)

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